## **REQUEST FOR LIVE SCAN SERVICE**

Applicant Submission

ORI: AO434 Type of Application: License, Certification, Permit						
Job Title or Type of License, Certification or Permit: Doctor of Podiatric Medicine						
Agency Address Set Contributing A	gency:					
Board of Podiatric Medicine		03802				
Agency authorized to receive criminal histor	y information	Mail Code (five digit code assigned by DOJ)				
1420 Howe Avenue #8		Patty Rodriguez				
Street No. Street or P.O. Box		Contact Name (Mandatory for all school submissions)				
Sacramento CA	95825	(916) 263-				
City State	Zip Code	Contact Telepho	one No.			
Name of Applicant: (please print)  Last	First		MI			
		D. Jallanaa N				
Alias: Last	First	_ Driver's License N	lo			
Data of Dieth.		Micc No BU	DII 100026			
Date of Birth: Sex	:    Male   remale	Misc. No. BIL	Agency Billing Number (if applicable)			
Height: We	iaht <sup>.</sup>	Misc No:				
	giit	141100. 140.	<del></del>			
Eye Color: Hair	Color:	Home Address:	N/A			
Place of Birth:		N/A				
SOC#		City, State and Zip Code				
		_				
Your Number:		Level of Service	X DOJ X FBI			
OCA No. (Agency Idea	ntifying No.)					
If resubmission, list Original ATI No	ı.					
Employer: (Additional response for agend	ies specified by statute)					
N/A						
Employer Name						
N/A			N/A			
Street No. Street or P.O	. Box	Mail Co	ode (five digit code assigned by DOJ)			
N/A	Zip Code	( <u>)</u>	N/A y Telephone No. (optional)			
City State	ZIP Code	Agency	у Гегерпопе №. (орнопаг)			
Live Scan Transaction Completed By: Date: Date:						
Transmitting Agency	ATI No.		Amount Collected/Billed			

## **REQUEST FOR LIVE SCAN SERVICE**

Applicant Submission

ORI: A0434 Type of Application: License, Certification, Permit						
Job Title or Type of License, Certification or Permit: Doctor of Podiatric Medicine						
Agency Address Set Co	ontributing Agen	cy:				
Board of Podiatric		•	03802	03802		
Agency authorized to receive		rmation	Mail Code (five digit code assigned by DOJ)			
1420 Howe Avenue #8			Patty Rodriguez			
Street No. Street or P.O. Box			Contact Name (Mandatory for all school submissions)			
Sacramento	CA	95825	(916) 26	3-2649		
City	State	Zip Code	Contact Telep			
Name of Applicant:						
(please print)	Last	First		MI		
Alias:			Driver's License	Driver's License No.		
Last		First	<del>-</del>			
Date of Birth:	Sex:	Male Female	Misc. No. BIL-	BIL - 100026		
		<u> </u>		Agency Billing Number (if applicable)		
Height:	Weight:		Misc. No:			
5 - O-1	Unio Onla		Ularra Addinana	NI/A		
Eye Color:	Hair Coid	or:	Home Address:	Street or P.O. Box		
				N/A		
Place of Birth:		City, State and Zip Code				
SOC#			_	,		
Your Number:			Level of Service	X DOJ X FBI		
OCA N	o. (Agency Identifyin	g No.)				
If resubmission, list Orig	ginal ATI No					
Employer: (Additional resp		pecified by statute)				
	N/A					
Employer Name						
N/A		N/A				
Street No. Street or P.O. Box		Mail Code (five digit code assigned by DOJ)				
	N/A			) N/A		
City	State	Zip Code	Agei	ncy Telephone No. (optional)		
Live Scan Transaction Completed By: Date:				Date:		
		Name of Operator				
Transmitting Agency		ATI No.		Amount Collected/Billed		

## **REQUEST FOR LIVE SCAN SERVICE**

Applicant Submission

ORI: A0434 Type of Application: License, Certification, Permit						
Job Title or Type of License, Certification or Permit: Doctor of Podiatric Medicine						
Agency Address Set Co	ontributing Agen	cy:				
Board of Podiatric		•	03802	03802		
Agency authorized to receive		rmation	Mail Code (five digit code assigned by DOJ)			
1420 Howe Avenue #8			Patty Rodriguez			
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(please print)	Last	First		MI		
Alias:			Driver's License	Driver's License No.		
Last		First	<del>-</del>			
Date of Birth:	Sex:	Male Female	Misc. No. BIL-	BIL - 100026		
		<u> </u>		Agency Billing Number (if applicable)		
Height:	Weight:		Misc. No:			
5 - O-1	Unio Onla		Ularra Addinana	NI/A		
Eye Color:	Hair Coid	or:	Home Address:	Street or P.O. Box		
				N/A		
Place of Birth:		City, State and Zip Code				
SOC#			_	,		
Your Number:			Level of Service	X DOJ X FBI		
OCA N	o. (Agency Identifyin	g No.)				
If resubmission, list Orig	ginal ATI No					
Employer: (Additional resp		pecified by statute)				
	N/A					
Employer Name						
N/A		N/A				
Street No. Street or P.O. Box		Mail Code (five digit code assigned by DOJ)				
	N/A			) N/A		
City	State	Zip Code	Agei	ncy Telephone No. (optional)		
Live Scan Transaction Completed By: Date:				Date:		
		Name of Operator				
Transmitting Agency		ATI No.		Amount Collected/Billed		